FY06 HEALTH PLAN DESCRIPTION FORM –PPO				
	PPO - 1500		PPO - 3500	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Important Note: This form is not a contract. It is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance options reflect the amount the carrier will pay.				
Part A: Type of Coverage				
1. Type of Plan	Preferred Provider Organization			
2. Out-of-Network Care Covered?[1]	Yes, but patient pays more for out-of-network care.			
3. Areas of Colorado where Plan is Available	Plan is available throughout Colorado			
Part B: Summary of Benefits				
4. Annual Deductible				
a) Individual	$1,500	$3,000	$3,500	$7,000
b) Family	$3,000	$6,000	$7,000	$14,000
5. Out-of-Pocket maximum per plan year[2]				
a) Individual	$7,000	$14,000	$7,500	$15,000
b) Family	$14,000 No cross application between in/out network	$28,000 No cross application between in/out network	$15,000 No cross application between in/out network	$30,000 No cross application between in/out network
6. Lifetime or Benefit Maximum Paid by the Plan for All Care	Not applicable			
7A.Covered Providers	Great-West Healthcare Preferred Provider Network; Pharmacy Services provided by Express Scripts by arrangement with Great-West Healthcare	All providers licensed or certified to provide covered benefits.	Great-West Healthcare Preferred Provider Network; Pharmacy Services provided by Express Scripts by arrangement with Great-West Healthcare	All providers licensed or certified to provide covered benefits.
7B.With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Not applicable	Yes	Not applicable
8. Routine Medical Office Visits	80%	60%	70%	50%
9. Preventive				
a) Children's services	80%	60%	70%	50%
b) Adults' services	80% not subj. to deduct	60% not subj. to deduct	70% not subj. to deduct	50% not subj. to deduct
10. Maternity				
a) Prenatal care	80%	60%	70%	50%
b) Delivery & Inpatient well baby care	80%	60%	70%	50%
11. Prescription Drugs Level of coverage and restrictions on prescriptions a) **Retail**		Not covered		Not covered
- Generic	$10		$10	
- Brand Name	$25		$25	
- Non-formulary	$50 after $100 per person Rx deductible (30 day supply) (Rx deductible applies in/out network &		$50 after $100 per person Rx deductible (30 day supply) (Rx deductible applies in/out network & retail/mail order.)	

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	retail/mail order.)			
b) **Mail Order** - Generic - Brand Name - Non-formulary	$20 $50 $100 after $100 per person Rx deductible (90 day supply) (Rx deductible applies in/out network & retail/mail order.)		$20 $50 $100 after $100 per person Rx deductible (90 day supply) (Rx deductible applies in/out network & retail/mail order.)	
c) **Self-admin. injectibles disp. thru pharmacy**	Member pays 30%, not to exceed $250 per 34 day supply or $500 per 90 day supply		Member pays 30%, not to exceed $250 per 34 day supply or $500 per 90 day supply	
d) **Injectibles admin. in office or OP facility**	70%, after medical deductible		70%, after medical deductible	
12. Inpatient Hospital	80%	60%	70%	50%
13. Outpatient/Ambulatory Surgery	80%	60%	70%	50%
14. a) **Laboratory**	80%	60%	70%	50%
b) **X-ray**	80%	60%	70%	50%
c) **MRI/PET/CAT scans**	80%	60%	70%	50%
15. Emergency Care[3]	80%	60%	70%	50%
16. Ambulance a) **Ground**	80% maximum benefit $350	80% maximum benefit $350	70% maximum benefit $350	70% maximum benefit $350
b) **Air**	80% maximum benefit $2,500	80% maximum benefit $2,500	70% maximum benefit $2,500	70% maximum benefit $2,500
17. Urgent Care a) **Inpatient**	80%	60%	70%	50%
b) **Outpatient**	80%	60%	70%	50%
18. Biologically Based Mental Illness[4] **Care**	80%	60%	70%	50%
19. Other Mental Health Care a) **Inpatient care**	80%, 45 full/90 partial days per year, number of days for both in/out network, combined with Alcohol & Substance Abuse	60%, 45 full/90 partial days per year, number of days for both in/out network, combined with Alcohol & Substance Abuse	70%, 45 full/90 partial days per year, number of days for both in/out network, combined with Alcohol & Substance Abuse	50%, 45 full/90 partial days per year, number of days for both in/out network, combined with Alcohol & Substance Abuse
b) **Outpatient care**	80%, 30 visits yr, number of visits for both in/out network, combined with Alcohol & Substance Abuse	60%, 30 visits yr, number of visits for both in/out network, combined with Alcohol & Substance Abuse	70%, 30 visits yr, number of visits for both in/out network, combined with Alcohol & Substance Abuse	50%, 30 visits yr, number of visits for both in/out network combined with Alcohol & Substance Abuse
20. Alcohol & Substance Abuse a) **Inpatient Rehab**	80%, 45 full /90 partial days per year / 60 days lifetime, combined with other mental health	60%, 45 full /90 partial days per year / 60 days lifetime, combined with other mental health	70%, 45 full /90 partial days per year / 60 days lifetime, combined with other mental health	50%, 45 full /90 partial days per year / 60 days lifetime, combined with other mental health

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b) **Outpatient**	80%, 30 visits per year, combined with other mental health, 60 visits lifetime, number of visits for both in/out network	60%, 30 visits per year, combined with other mental health, 60 visits lifetime, number of visits for both in/out network	70%, 30 visits per year, combined with other mental health, 60 visits lifetime, number of visits for both in/out network	50%, 30 visits per year, combined with other mental health, 60 visits lifetime, number of visits for both in/out network
21. Physical, Occupational & Speech Therapy				
a) **Inpatient**	80%	60%	70%	50%
b) **Outpatient**	80%, 20 visits / year for each therapy	60%, 20 visits / year for each therapy	70%, 20 visits / year for each therapy	50%, 20 visits / year for each therapy
22. Durable Medical Equipment				
a) **Inpatient**	80%	60%	70%	50%
b) **Outpatient including supp.**	80%; maximum $3,000/year, combined with oxygen (prosthetics not subject to $3000 max, but they do apply to, and reduce, the $3000 max)	65%; maximum $3,000/year, combined with oxygen (prosthetics not subject to $3000 max, but they do apply to, and reduce, the $3000 max)	70%; maximum $3,000/year, combined with oxygen (prosthetics not subject to $3000 max, but they do apply to, and reduce, the $3000 max)	50% ; maximum $3,000/year, combined with oxygen (prosthetics not subject to $3000 max, but they do apply to, and reduce, the $3000 max)
23. Oxygen				
a) **Inpatient**	Included in hospital	Included in hospital	Included in hospital	Included in hospital
b) **Outpatient**	Included in DME	Included in DME	Included in DME	Included in DME
24. Organ Transplants	80%	60%	70%	50%
25. Home Health Care	80%, 60 visits / year, number of visits for both in/out network	60%, 60 visits / year, number of visits for both in/out network	70%, 60 visits / year, number of visits for both in/out network	50%, 60 visits / year, number of visits for both in/out network
26. Hospice				
a) **Inpatient**	80%, 30 days / year	60%, 30 days / year	70%, 30 days / year	50%, 30 days / year
b) **Outpatient**	80%, 91 days / year	60%, 91 days / year	70%, 91 days / year	50%, 91 days / year
27. Skilled Nursing Facility Care	Not covered	Not covered	Not covered	Not covered
28. Dental Care	Not covered	Not covered	Not covered	Not covered
29. Vision Care	$50 copay, one exam every 12 months. Discounted lenses/hardware. In-network benefit provided by Avesis.	Up to $35 for one exam every 12 months.	$50 copay, one exam every 12 months. Discounted lenses/hardware In-network benefit provided by Avesis.	Up to $35 for one exam every 12 months.
30. Chiropractic Care	80%, maximum benefit $750/year, maximum applies to both in/out network	60%, maximum benefit $750/year, maximum applies to both in/out network	70%, maximum benefit $750/year, maximum applies to both in/out network	50%, maximum benefit $750/year, maximum applies to both in/out network
31. Significant Additional Covered Services	Hearing aid: up to $500 every 3-years, limit applies to both in/out network. Infertility: 80%, maximum benefit $2,500/year, limit applies to both in/out network.	Hearing aid: up to $500 every 3-years, limit applies to both in/out network. Infertility: 60%, maximum benefit $2,500/year, limit applies to both in/out network.	Hearing aid: up to $500 every 3-years, limit applies to both in/out network. Infertility: 70%, maximum benefit $2,500/year, limit applies to both in/out network.	Hearing aid: up to$500 every 3-years, limit applies to both in/out network. Infertility: 50%, maximum benefit $2,500/year, limit applies to both in/out network.
Part C: Limitations and Exclusions				
32. Period During which Pre-Existing Conditions are not Covered[5]	Not applicable. Plan does not impose limitation periods for pre-existing conditions			

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33. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No			
34. How Does the Policy Define a "Pre-existing Condition"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.			
35. What Treatments & Conditions are Excluded Under this Policy?	See summary plan description for list of exclusions.			
Part D: Using the Plan				
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes	Yes	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Great-West Healthcare	No	Yes, unless the provider participates with Great-West Healthcare
39. What is the main customer service number?	1-888-ST8-OFCO (1-888-788-6326)			
40. Whom do I write/call if I have a complaint or want to file a grievance?[6]	Great-West Healthcare P.O. Box 22222 Fort Scott, KS 66701 (1-800-663-8081)			
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?				
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy Number 179528 Self-funded large group.			
43. Does the plan have a binding arbitration clause?	No			
Part E: Cost				
44. What is the cost of this plan? a) **Employee Only** b) **Employee + Child(ren)** c) **Employee + Spouse** d) **Family**	Final rates will be made available via the Benefits newsletter, *HealthLine*, and on the Benefits website www.colorado.gov/dpa/dhr/benefits.			

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT

[1]"Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

[2]Out-of-pocket maximum. The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copay, depending on the contract for that plan.

[3]"Emergency care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

[4]"Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[5]Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.
[6]Grievances. The formal grievance process (not to be confused with appeals) is in development.